
# 2019 IHCP Annual Workshop

## MDwise CMS-1500/UB-04

*Providing health coverage to Indiana families since 1994*

# Agenda

- Eligibility
- Prior Authorization
- Claim Submission
- Billing Requirements
- Denial vs. Rejection
- Claim Adjustments
- Resources
- Contact
- Questions


# ELIGIBILITY

# Eligibility

When determining eligibility, verify:

- Is the member eligible for services today?
- In which Indiana Health Coverage Program plan are they enrolled?
- If the member is in Hoosier Healthwise or Healthy Indiana Plan, are they assigned to MDwise?
- Who is the member's Primary Medical Provider (PMP)?

| IHCP Provider Healthcare Portal | myMDwise Provider Portal |
|---|---|
| • IHCP Program | • Delivery System: MDwise Excel |
| • MCE | • Assigned PMP History |
| • Assigned PMP | |
| • Delivery System: MDwise Excel | |


# PRIOR AUTHORIZATION

# Prior Authorization

## Prior Authorization Resources

- Prior Authorization Page:
  - https://www.mdwise.org/for-providers/forms/prior-authorization
- Prior Authorization Reference Guide
  - Contact information for Excel Hoosier Healthwise and HIP
  - PA review timelines
  - PA appeals process
- 2019 Medical Prior Authorization & Exclusion List
- 2019 Behavioral Health Prior Authorization List

# Prior Authorization

You will need two key items when filing a request for Medical Prior Authorization (PA):

1. Universal Prior Authorization Form
   - Located on our website here: https://www.mdwise.org/for-providers/forms/prior-authorization
2. Documentation to support the medical necessity for the service you are requesting:
   - Lab work
   - Medical records/physician notes
   - Test results
   - Therapy notes

## Tips:

- Completely fill out the Universal PA Form including the rendering provider's NPI and TIN, the requestor's name along with phone and fax number.
- Be sure to note if PA is for a retroactive member.

Please Note: Not completely filling out the Universal PA Form may delay the prior authorization timeframe.

# Prior Authorization

## Prior Authorization Turn-Around Time

- All emergency inpatient admissions require prior authorization within 48 hours after admission.
- Urgent prior authorizations can take up to 72 hours to be addressed.
  - It is important to note that "addressed" could mean a decision to pend for additional information.
- Requests for non-urgent prior authorization will be addressed within 7 calendar days.
  - "Addressed" could mean a decision to pend for additional information.
- If you have not received a response within the time frames above, contact the Prior Authorization Inquiry Team and they will research the issue.
- PA Inquiry Line
  - 1-888-961-3100

# Prior Authorization

## Appeals

- Providers can request a prior authorization appeal on behalf of a member within 60 calendar days of receiving denial.
- Providers must request an authorization appeal in writing to MDwise:

  MDwise Customer Service Department
  PO Box 441423
  Indianapolis, IN 46244-1426

- MDwise will respond to an appeal within 30 calendar days and notify the provider and member in writing of the appeal decision including the next steps.
- If you do not agree with the appeal decision, additional appeal procedure options are available.

# Prior Authorization

## Pharmacy Prior Authorizations

- For all requests and questions regarding Pharmacy PA, contact the Pharmacy Benefit Manager.
  - MedImpact: 844-336-2677
- Pharmacy Resources:
  - http://www.MDwise.org/for-providers/pharmacy-resources


# CLAIM SUBMISSION

# Claim Submission

- Beginning in 2019, MDwise moved claims processing in-house for dates of service 1/1/19 and forward. This included a new claim submission address, as well as new electronic payer IDs for Hoosier Healthwise and Healthy Indiana Plan.

- As of 6/1/19, all claims submitted to MDwise, regardless of date of service, are to be submitted to the new address and payer IDs.

# Claim Submission for Medical and Behavioral Health

- Paper claims:
  MDwise/McLaren Health Plans
  P.O. Box 1575
  Flint, MI 48501

- Electronic submission:
  Hoosier Healthwise EDI/Payer ID: 3519M
  Healthy Indiana Plan EDI/Payer ID: 3135M

Please note: Paper claims must be on red/white form with black ink.

# Claim Submission

## Claim Timelines:

- Claim Submission:
  - Primary: 90 days from the date of service
  - Secondary: 90 days from the date of the explanation of benefits (EOB)
  - Non-contracted providers will have 180 days for claim submission.
- MDwise Adjudication: (clean claims)
  - Electronic Claims: 21 days
  - Paper Claims: 30 days
- Claim Disputes:
  - 60 calendar days from the date of the EOB
  - Dispute Response: 30 calendar days from date of submission


# BILLING REQUIREMENTS

## Billing requirements for CMS-1500:

- Box 24J: Rendering provider NPI
- Box 33: Group/billing provider's service location address with complete ZIP code+4 (no PO Box or remit address)
- Box 33A: Group billing provider NPI
- Box 33B: Group billing taxonomy code

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Be sure you report all of your NPI numbers and taxonomies with the State of Indiana at www.IN.gov/Medicaid.

## Billing requirements for UB-04

- Box 1: Billing provider service location name, address and expanded ZIP Code+4
- Box 56: NPI for the billing provider
- Box 81ccA: Billing taxonomy (required eff. 9/1/19)

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Remember to attest all of your NPI numbers with the State of Indiana at www.IN.gov/Medicaid.


# DENIAL VS. REJECTION

## Denial vs. Rejection

- Denied claims will include an EOB with a denial code.
- Rejected claims are different than denied claims:
  - Rejected claims are returned to the provider or electronic data interchange (EDI) source without registering in the claim processing system.
  - Since rejected claims are not registered in the claims processing system, the provider must resubmit the claim within the claims timely filing limit.
- Rejected claims do not extend the timely filing limit.
  - Contracted providers have 90 days from the date of service


# CLAIM ADJUSTMENTS

# Claim Adjustments

## Claim Adjustment Request Form

- Became available 1/1/19
- Request for payment reconsideration for a paid or denied claim
- Claim adjustments are to be used before the Claim Dispute process
- Use form:
  - To have claim reconsidered for payment if denied in error
  - If claim paid at inappropriate rate
  - To submit attachments missing from original claim submission
- All claim adjustment inquiries and requests must be made to MDwise within 90 calendar days of the most current MDwise Explanation of Payment (EOP)
- Form cannot be used if claim has already been disputed
- Adjustment Request Form must be complete and include all documentation to be considered

# Claim Adjustment Request Form

**COMPLETE THE FOLLOWING REQUIRED INFORMATION:**

Member Name: _____ MID #: _____

MDwise Claim #: _____ DOS: _____

Provider Name: _____ Tax ID#: _____

Office Contact: _____ Rendering NPI #: _____

Date *Provider Claim Adjustment Form* Submitted: _____ Phone #: _____

**Reason for Request (please check appropriate box):**

**For a correction to a previously submitted claim:**

- ☐ Date of Service
- ☐ Diagnosis Code
- ☐ Modifier
- ☐ Place of Service
- ☐ Procedure Code
- ☐ Provider/Tax ID
- ☐ Other: _____

**For reconsideration: (supporting documentation required)**

- ☐ Service denied for lack of authorization (attach copy of authorization information or number)
- ☐ Service denied as other insurance primary (COB) (attach copy of primary EOB)
- ☐ Service denied as a duplicate (attach documentation)

# Claim Adjustments

## Claim Adjustment Request Form

- Send completed Claim Adjustment Request Form with a copy of the claim form and/or any supporting documentation to:
  - MDwiseClaims@mclaren.org
  - Or fax to: 833-540-8649
- For questions regarding the Provider Claims Adjustment Process, call the Provider Customer Service Unit (PCSU) at 1-833-654-9192.

# Claim Disputes

## Claim Dispute Process:

1. Provider completes the Claims Dispute Form found at www.mdwise.org on the For Providers page, under Claim Forms.
2. Completed form and supporting documents are sent via email:
   - cdticket@mdwise.org
3. Received email is routed to a Claims Dispute work queue where a ticket number will be issued and an email notification will be sent back immediately.
4. The Claim Dispute team will review the submitted dispute and work the cases to resolution (uphold or overturn).
5. An email notification will then be sent to the provider, referencing the dispute and ticket number, on the resolution determination.

*Providers may submit the Claims Dispute Form by mail, if they prefer, to:

MDwise

P.O. Box 441423

Indianapolis, IN 46244-1423

Attn: MDwise Dispute Team



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# Claim Disputes

## Informal Claim Dispute

- Provider disagrees in writing with how the claim was adjudicated:
  - Must be commenced within 60 days from the date on the Explanation of Payment (EOP).
  - MDwise will reach a decision and notify provider within 30 calendar days.

## Formal Claim Dispute

- Provider disagrees with 1st level decision:
  - Provider has 60 days from the date of the 1st level decision.
  - MDwise will compose a panel of persons not involved with the 1st level dispute to review the 2nd level dispute.
  - MDwise will reach a decision and notify provider within 45 calendar days.
  - The panel's decision is MDwise's final action on the claim for an in-network provider. Out-of-network providers may request arbitration review of the panel's decision. This request must be submitted within 60 calendar days of the 2nd level dispute decision.


# RESOURCES AND CONTACT INFORMATION

# Resources

## Claims Page

- https://www.mdwise.org/for-providers/claims

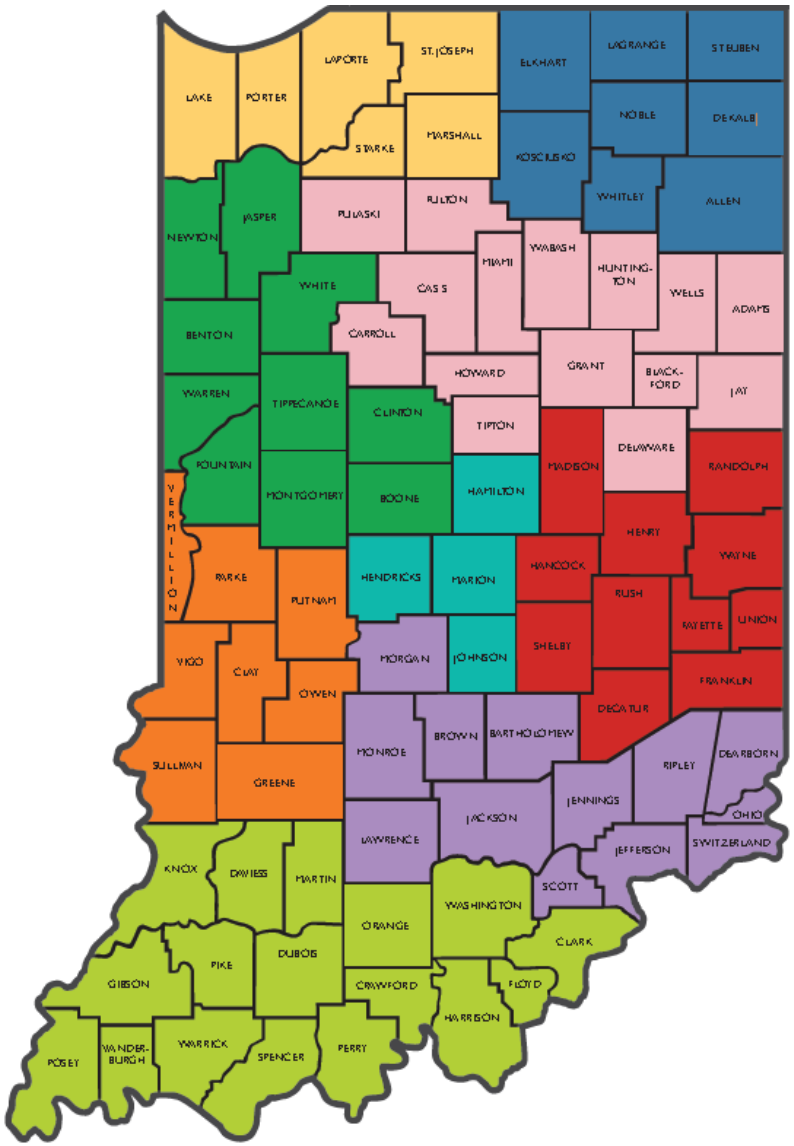
## Claims Forms

- https://www.mdwise.org/for-providers/forms/claims
  - Claim Adjustment Request Form
  - Claims Dispute Form
  - Provider Refund Remittance Form
  - Vision Eligibility Request Form

## Claims Inquiries

- Providers can use the myMDwise provider portal to quickly view the status of their claims.

# Provider Relations




Region 1
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317-822-7490

Region 2
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317-983-6137

Region 3
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Region 4
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317-822-7276

Region 5
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Region 6
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Region 8
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Region 9
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Nichole Young, RN
nyoung@mdwise.org
317-822-7509
*Behavioral Health*
*CMHCs, OTPs, IMDs, Residential)*



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# Provider Relations

| Representative | Territory | Phone | Email |
|---|---|---|---|
| Paulette Means | Region 1 | 317-822-7490 | pmeans@mdwise.org |
| TA Ward | Region 2 | 317-983-6137 | tward@mdwise.org |
| Michelle Phillips | Region 3, Hospice, Home Health | 317-983-7819 | mphillips@mdwise.org |
| Jamaal Wade | Region 4 | 317-822-7276 | jwade@mdwise.org |
| David Hoover | Region 5 | 317-983-7823 | dhoover@mdwise.org |
| Tonya Trout | Region 6 | 317-308-7329 | ttrout@mdwise.org |
| Rebecca Church | Region 7 | 317-308-7371 | rchurch@mdwise.org |
| Sean O'Brien | Region 8 | 317-308-7344 | sobrien@mdwise.org |
| Whitney Burnes | Region 9 | 317-308-7345 | wburnes@mdwise.org |
| Nichole Young | Behavioral Health (CMHC, OTP, IMD or Residential) | 317-822-7509 | nyoung@mdwise.org |



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# Resources

myMDwise Provider Portal

http://www.MDwise.org/for-providers

- Member Eligibility, including Primary Medical Provider
- Claims
- Quality Reports
  - Member Rosters
- Member Health Profile
  - Coordinate Medical and Behavioral Health services based on paid claims
  - Includes physician visits, medication and ER visits
- Case Management/Disease Management Requests

# Resources

MDwise Provider Tip Sheets

- http://www.mdwise.org/for-providers/tools-and-resources/additional-resources/tip-sheets/

MDwise Provider Manuals

- http://www.mdwise.org/for-providers/manual-and-overview/

MDwise Provider Relations Territory Map

- http://www.mdwise.org/for-providers/contact-information/

MDwise Claims: Provider Customer Service Unit

- 1.833.654.9192

MDwise Customer Service

- 1.800.356.1204

IHCP Provider Modules

- www.in.gov/providers

# Questions



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# Session Survey - Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1005

# Session Survey - Thursday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1039



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